Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Date notice sent to all parties: 05/19/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right knee arthroscopy, partial medial meniscectomy, and chondroplasty of the medial femoral condyle and trochlea

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Orthopedic Surgery
Diplomate of the American Board of Orthopedic Surgery
Fellow of the American Association of Orthopedic Surgeons

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Right knee arthroscopy – Upheld
Partial medial meniscectomy – Upheld
Chondroplasty of the medial femoral condyle and trochlea - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
Per a patient history on XX/XX/XX, the patient was on Norvasc and had hypertension. His past surgical history was positive for pancreatitis and left knee torn meniscus. He was a tobacco user. XX examined the patient on XX/XX/XX. He had left shoulder pain from a work injury sustained on XX/XX/XX. He was handling heavy freight and he had no night pain. There was some neck soreness, but no parethesias. He was XXX feet XXXX inches tall and weighed XXX pounds. His pulse was XXX and his blood pressure was XX/XX. He had

full forward flexion and external rotation in the left shoulder, but he had decreased internal rotation, which went to the intertrochanteric level. Impingement signs and Hawkin's were negative. X-rays revealed a type II acromion. The impression was left shoulder type II SLAP tear, as well as adhesive capsulitis. Therapy and an MRI were recommended. He would remain off of work. An MR arthrogram of the left shoulder was performed on XX/XX/XX. It revealed findings concerning for degenerative tear of the superior glenoid labrum, i.e. type I SLAP tear. There was an extensive tear of the posterosuperior glenoid labrum with adjacent 2.3 x 1.5 s 1.9. paralabral cyst extending into the spinoglenoid notch. There was no evidence of infraspinatus muscle atrophy or edema. There was also a non-detached inferior glenoid labrum tear with adjacent paralabral cyst formation. Low grade undersurface fraying of the leading edge of the fibers of the distal supraspinatus tendon was noted without evidence of full thickness rotator cuff tear. There was also moderate-severe osteoarthritic change of the glenohumeral joint with associated full thickness chondral loss along the posterior glenoid. On XX/XX/XX, XX reexamined the patient. He felt almost 100% better with significant improvements in range of motion. He had been off work. He had full range of motion and impingement signs were negative. The MR arthrogram was reviewed. The impression was osteoarthritis and degenerative changes in the left shoulder with degenerative labral tearing and full thickness chondral loss of the posterior glenoid, as well as resolving adhesive capsulitis. He was advised to finish therapy and he was returned to work without restrictions. The patient followed-up on XX/XX/XX. He was 85-90% back to normal and his examination was essentially unchanged. XX noted they would hold off on injections since he was doing so well and did not want one at that time. He was back to full duty and he would be referred for an impairment rating. XX noted the patient would likely have issues with his shoulder long term due to the osteoarthritis of his glenohumeral joint. A right knee MRI was obtained on XX/XX/XX. There was a meniscal contusion of the posterior junctional zone of the medial meniscus with marrow contusion and short, incomplete and non-displaced subchondral fracture of the central third of the medial femoral condyle. It was suspected that there was an inner third and inferior articular surface flap tear of the medial meniscal body. There was no centrally displaced meniscal fragment. There was high grade chondral erosion of a 12 x 18 mm. segment of the central to posterior third of the medial femoral condyle and a 6 x 3 mm. segment of the posterior third of the lateral femoral condyle. There was a mild sprain of the fibular collateral ligament and a grade I tear of the medial collateral ligament. The cruciate ligaments were intact and there was a grade III trochlear groove chondromalacia without high grade patellar chondromalacia or patellar marrow contusion. There was mild distal quadriceps and distal patellar tendinosis without fluid filled tendon tear. There was mild deep infrapatellar bursitis and tibial collateral ligament bursitis. A moderate to large effusion with non-specific suprapatellar pouch synovitis and the synovitis also involved the inferior component of a 4.1 a 1.1 cm. popliteal cyst. On XX/XX/XX, the patient returned to XX. He was XX-years-old and had pain in his right knee after injuring it at work on XX/XX/XX. He noted he had swelling. He was XXX

feet XXXX inches tall and weighed XXX pounds. He had an antalgic gait and had no atrophy in the right lower extremity. He had a mild effusion and mild swelling. He had medial joint line and MCL and LCL tenderness. Lachman's and lateral McMurray's were negative, but medially, McMurray's was positive. Valgus stress was positive, but varus stress testing was negative. Range of motion was 0-135 degrees, which was the same as the left knee. Strength was normal in the bilateral lower extremities. X-rays were noted to show no fracture. The assessment was right knee pain, complex tear of the medial meniscus, chondromalacia of the patella, sprain of the LCL, and a sprain of the MCL. XX recommended right knee arthroscopy, PMM, and chondroplasty of the MFC and trochlea. A preoperative visit was done and he was placed on modified duty. On XX/XX/XX, a preauthorization request was made for the right knee surgery, which XX provided an adverse determination for on XX/XX/XX. On XX/XX/XX, a reconsideration preauthorization request was submitted, which XX, provided another adverse determination for on XX/XX/XX.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient is a male who reportedly sustained a work-related injury on or about XX/XX/XX when he jumped off of a piece of equipment at work. Physical examination on XX/XX/XX documented pain free range of motion from 0 degrees to 135 degrees, normal strength, no joint locking, a medial McMurray, and a positive valgus stress. MRI scan performed revealed degenerative changes, most notably Grade III trochlear groove chondromalacia, synovitis with popliteal cyst, quadriceps and patellar tendinosis, chondral erosion of the medial femoral condyle, and meniscal contusion with a questionable flap tear. These are clearly degenerative in nature and not the result of any acute injury. In addition, there was reported to be a non-displaced subchondral fracture of the medial femoral condyle. There is no evidence of an adequate trial of conservative treatment based on the documentation provided for my review. The subchondral fracture was not addressed by the requesting physician. The request was denied on initial review. XX denial was upheld on reconsideration/appeal by XX. Both reviewers' opinions were based upon the request not meeting the criteria as outlined by the evidence based ODG.

The ODG indications for surgery, meniscectomy, include the following: The criteria for meniscectomy or meniscal repair (suggest two symptoms and two signs to avoid scopes with lower yield, e.g., pain with other symptoms, posterior joint line tenderness that could signify arthritis, MRI scan with degenerative tear that is often false positive). Physiologically younger or more active patients with traumatic injuries and mechanical symptoms, locking, blocking, catching, etc., should undergo arthroscopy without physical therapy. Criteria: 1) Conservative care (not required for locked or blocked knees), exercise/physical therapy, supervised PT, and/or home rehabilitation exercises if compliance is adequate, and medication or activity modification, i.e., crutches and/or immobilizer; plus 2) subjective clinical findings, at least two, joint pain or swelling or feelings of giving away or locking, clicking, or popping; plus 3) objective clinical findings, at least

two, positive McMurray sign or joint line tenderness or effusion or limited range of motion or locking, clicking, or popping or crepitus; plus 4) imaging clinical findings, which are not required for a locked or blocked knee, meniscal tear on MRI scan (Washington 2003). The ODG for chondroplasty, which includes shaving or debridement of an articular surface, require all of the following: 1) Conservative care, medication or physical therapy; plus 2) subjective clinical findings, joint pain and swelling; plus 3) objective clinical findings, effusion or crepitus or limited range of motion; plus 4) imaging clinical findings to include a chondral defect on MRI scan (Washington 2003) (Hunt 2002) (Janecki 1999). The patient's symptoms of pain and swelling may be the result of the subchondral fracture reported on the MRI scan. The fracture would be expected to improve in six to eight weeks with conservative treatment. The patient did not exhibit any mechanical symptoms, locking, catching, or blocking based on the objective documentation reviewed. He demonstrated pain free range of motion of 0-135 degrees. There is no documentation of an adequate trial of conservative treatment to include physical therapy/supervised home exercise program, medication, or activity modification. Therefore, the requested right knee arthroscopy, partial medial meniscectomy, and chondroplasty of the medial femoral condyle and trochlea is not medically necessary, reasonable, related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- **X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISO**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**